Additional Error Codes and Explanations

This flier provides a narrative description of certain error codes providers may receive on their remittance advice. These codes have not yet been published in your MassHealth provider manual. Pharmacy providers may also encounter some of them at the time of an on-line transaction. For error codes not listed here, continue to consult part 5.9 of your MassHealth billing instructions.

Error No.	Error Description
058	A less costly method of service or treatment is available.
060	This service is not reimbursable by MassHealth.
061	A report containing a higher level of detail must be attached to the claim.
062	The **procedure code** entered on the claim is incorrect for this service.
063	The **procedure code modifier** entered on the claim is incorrect for this service.
065	Payment included in primary procedure.
067	Reimbursement for this service has been made to another physician.
078	A **CLIA certification number** is not on file; contact Provider Enrollment.
079	The **date of service** entered on the claim is prior to the effective date of **CLIA certification**.
080	The **date of service** entered on the claim is after the expiration date of **CLIA certification**.
081	The **CLIA certification** information on file does not allow for reimbursement for this service.
086	Benefits exhausted.
088	The **value code** entered on the claim conflicts with the **patient status** code entered on the claim.
089	The **Admission Type Code** is invalid or missing**.**
096	This claim is a duplicate of a previously paid claim.
111	This claim is a duplicate of a claim previously paid as a **Medicare/MassHealth crossover claim** for the same date of service.
112	This claim is a duplicate of a claim previously paid as a **Medicare/MassHealth crossover claim** for the same date of service.
113	This claim is a duplicate of a claim previously paid for the **same date of service**.
114	This service is a component of a comprehensive procedure for which reimbursement has been made; this component will not be reimbursed separately.
115	This component of a comprehensive service has already been reimbursed.
116	The combination of this procedure and at least one other comprehensive and bundling procedure submitted either on the **same claim form** or on a **previous claim form**, for the same member, on the same date of service, to the same provider is not allowed.
134	**Shoe Prescription Form** missing.
135	This **service code** requires a modifier.
141	The **from and through** dates of service entered on the claim span both a contractual and non-contractual period; the claim must be split-billed.
149	Member not enrolled in hospice.
184	Zero pay claim.
188	The **procedure code** entered on the claim is not covered for members enrolled in this **coverage type**.
192	The **certification of medical necessity** attached to the claim requires review. (If this claim was billed electronically, it should be submitted on paper.)
193	Certification of medical necessity missing; the **procedure code** entered on the claim requires that **certification of medical necessity** be attached to the claim. (If this claim was billed electronically, it should be submitted on paper.)
290	This claim requires review. (If this claim was billed electronically, it should be submitted on paper.)
304	This claim requires review. (If this claim was billed electronically, it should be submitted on paper.)
358	Chiropractic services require review. (If this claim was billed electronically, it should be submitted on paper.)
359	This claim requires review. (If this claim was billed electronically, it should be submitted on paper.)
474	**Revenue codes** 360-369 entered on the claim are not covered by MassHealth on the same **date of service** when billed with **revenue codes** 490-499.
479	The **revenue code rate of payment** is not on file.
480	The **revenue code** entered on the claim is not covered by MassHealth on the **date of service** entered on the claim.
482	**Senior Pharmacy** must be billed through **POPS**.
483	Claims for **substance abuse and mental health services** must be submitted to MassHealth's **Behavioral Health contractor**.
484	The member's **coverage type** is buy in/subsidy only.
486	The **procedure code** entered on the claim is not covered for members enrolled in this **coverage type**; the member is enrolled in MassHealth Basic.

Additional Error Codes and Explanations (cont.)

Error No.	Error Description
487	The **procedure code** entered on the claim is not covered for the member's **coverage type**.
488	The **procedure code** entered on the claim is not covered for members enrolled in this **coverage type**; the member is enrolled in MassHealth Limited.
489	The **procedure code** entered on the claim is not covered for members enrolled in this **coverage type**; the member is enrolled in MassHealth Family Assistance.
544	The **procedure code** entered on the claim requires that the service be performed by the member's **PCC**.
547	The member is enrolled in Managed Care, and therefore, is required to have this service provided by their **PCC**.
548	The member is enrolled in Managed Care, was seen in the emergency department, and a screening was provided. Additional inappropriate emergency-department screening services were also provided.
574	This provider is not authorized by MassHealth to perform the services entered on the claim.
575	The **provider number** entered on the claim is not on the MassHealth provider file; contact Provider Enrollment.
595	This **service** has been billed on previous and current claims.
597	The **procedure code** entered on the claim was **previously paid** for a new-patient or initial-visit; an established-patient or periodic-procedure code may be billed to MassHealth.
598	The **procedure codes** entered on the claim cannot be billed for the same member, on the same **date of service**.
605	The **procedure code** entered on the claim is not reimbursable by MassHealth to municipally-based health services providers.
673	The **number of MLOA days** are missing on the claim form.
674	The member was enrolled in Hospice care for the **from** and **to** dates of service entered on the claim.
675	The **number of MLOA or NMLOA days** entered on the claim are not reimbursable by MassHealth.
750	A **referring provider number** must be entered on all claim forms for chiropractor services.
761	Long-term-care contractual providers must also be casemix providers: contact Provider Enrollment.
777	The **date of service** is after the expiration of the PA.
799	Medical Necessity form incomplete.
809	The **number of minutes of waiting time** entered on the claim is not reimbursable by MassHealth if the **number of miles** entered on the claim is less than 40.
837	This claim was denied because it exceeded the 36-month deadline from the **date of service** entered on the claim.
847	This claim must be submitted on paper to MassHealth.
856	Services must be billed on a daily basis.
857	Services must be billed on a monthly basis.
858	The provider rate is not on file.
860	This claim requires review. (If this claim was billed electronically, it should be submitted on paper.)
880	The **tooth number** entered on the claim is invalid for the **procedure code** entered on the claim.
881	The **tooth surface code** entered on the claim is invalid for the **procedure code** entered on the claim.
884	This claim requires review. (If this claim was billed electronically, it should be submitted on paper.)
885	This claim requires review. (If this claim was billed electronically, it should be submitted on paper.)
886	Medical records missing; the **procedure code** entered on the claim requires that the medical records be attached to the claim. (If this claim was billed electronically, it should be submitted on paper.)
887	The medical record attached to the claim is incomplete.
913	APG Outlier review.
919	This claim requires review. (If this claim was billed electronically, it should be submitted on paper.)
922	This claim requires review. (If this claim was billed electronically, it should be submitted on paper.)
923	The claim has been denied after prepayment review by the MassHealth contractor.
924	The **procedure code** entered on the Medicare/MassHealth claim must be billed on a MassHealth claim form.
951	The Medicare **type of service** code must be entered in **item 24C** of the HCFA-1500 claim form.
963	Invalid rate ID for admission date.
964	The **rate identification code** entered on the claim conflicts with the **treatment authorization code** entered on the claim.
966	The **dates of service** entered on the claim must be within the approval range of the pre-admission screening.